Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

MEMORIAL HERMANN HOSPITAL SYSTEM
3200 SW FREEWAY SUITE 2200
HOUSTON TX 77027

Respondent Name

LUMBERMENS UNDERWRITING ALLIANCE

Carrier's Austin Representative Box

Box Number 19

MFDR Tracking Number

M4-07-5702-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary dated May 2, 2007: "This patient was brought to Memorial Hermann Hospital via Life Flight air ambulance and admitted through the ER due injuries sustained in the course and scope of employment. The patient suffered severe head trauma as the result of a fall from 20 feet. The patient was hospitalized from May 4, 2006 through May 10, 2006." "At the very least, the hospital should be reimbursed no less than 75% of its billed charges as clearly this case exceeded the stop loss threshold for total billed charges." "In this case, the carrier paid just 24% of the hospital's usual and customary charges and did not pay any of the hospital's Life Flight air ambulance charges…The hospital billed its usual and customary charges in the total amount of $142,812.39 and $8,078.75, respectively…Requestor submits that a fair and reasonable rate for treatment of this injured employee is the usual and customary charges incurred since the carrier refused to conduct an audit to refute those charges. Requestor is owed an additional $114,064.02, plus interest."

Requestor's Supplemental Information submitted on January 18, 2012: "Per your phone call, attached is the Memorial Hermann Life Flight bill that was sent to Cambridge Integrated representing the carrier back on may 5, 2006. This bill is also part of the package originally submitted when requesting medical dispute resolution. It is the last two pages of the Memorial Hermann bill. Life Flight air ambulance is wholly owned by Memorial Hermann Hospital System. Back at this time, the hospital was still doing its own billing as you can see from the attached bill. We never received any payment or EOB from the carrier on this claim, even after requesting reconsideration. I found out that Life Flight only operates within a 150 mile radius of the Medical Center in Houston. So it does not transport patient from other states and operates solely in Texas."

Amount in Dispute: $114,064.02

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Carrier has not disputed that the treatments were rendered under a Trauma ICD-9 code." "Requestor billed a total of $150,891.14. Carrier has issued reimbursements totaling $36,827.12. This amount was the result of an item by item review of the billed amounts. The explanations of benefits shows each item and the reason or reasons for the reductions. As required by DWC rules, each reduction or denial is coded by ANSI codes. Carrier asserts that the reimbursement it has made does constitute a fair and reasonable reimbursement for the rendered services and that no additional reimbursements are owed."

Response Submitted by: Lumbermens Underwriting Alliance, FOL, P.O. Box 13367, Austin, TX 78711

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
May 4, 2006 Through May 10, 2006	Inpatient Services	$105,985.27	$0.00
May 4, 2006	Air Ambulance	$8,078.75	$0.00
TOTAL		$114,064.02	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.401(c)(5)(A), effective August 1, 1997, 22 *Texas Register* 6264, requires that when "Trauma (ICD-9 codes 800.0-959.50)" diagnosis codes are listed as the primary diagnosis, reimbursement for the entire admission shall be at a fair and reasonable rate.
3. 28 Texas Administrative Code §134.1, effective May 2, 2006, 31 *Texas Register* 3561, requires that, in the absence of an applicable fee guideline, reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with subsection §134.1(d) which states that "Fair and reasonable reimbursement: (1) is consistent with the criteria of Labor Code §413.011; (2) ensures that similar procedures provided in similar circumstances receive similar reimbursement; and (3) is based on nationally recognized published studies, published Division medical dispute decisions, and values assigned for services involving similar work and resource commitments, if available."
4. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
5. This request for medical fee dispute resolution was received by the Division on May 3, 2007.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of Benefits dated May 30, 2006
   - 16-Not All Info Needed for Adjudication was Supplied.
   - 500-Reimbursement amount based on U&C allowance.
   - B15-Procedure/Service is not paid separately.
   - W10-Payment based on fair & reasonable methodology.
   - 214-75% of Reasonable & Customary Charge.
   - 97-Charge Included in another Charge or Service.

   Explanation of Benefits dated August 16, 2006
   - 168-No additional allowance recommended.
   - 506-Re-evaluated bill, payment adjusted.
   - W1-Workers' Compensation State Fee Schedule Adj.
   - W3-Additional payment on appeal/reconsideration.
   - W10-Payment based on fair & reasonable methodology.
   - 214-75% of Reasonable & Customary Charge.
   - W4-No additional payment allowed after review.

Findings

1. This dispute relates to inpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of former 28 Texas Administrative Code §134.401(c)(5)(A), which requires that when "Trauma (ICD-9 codes 800.0-959.50)" diagnosis codes are listed as the primary diagnosis, reimbursement for the

entire admission shall be at a fair and reasonable rate. Review of box 67 on the hospital bill finds that the principle diagnosis code is listed as 801.22. The Division therefore determines that this inpatient admission shall be reimbursed at a fair and reasonable rate pursuant to Division rule at 28 Texas Administrative Code §134.1 and Texas Labor Code §413.011(d).

2. The requestor asks for reimbursement under the stop loss provision of the Division's *Acute Care Inpatient Hospital Fee Guideline* found in Division rule at 28 TAC §134.401(c)(6). The requestor asserts in the position statement that "At the very least, the hospital should be reimbursed no less than 75% of its billed charges as clearly this case exceeded the stop loss threshold for total billed charges." Division rule at 28 TAC §134.401(c)(6), effective August 1, 1997, 22 TexReg 6264, states, in part, that "The diagnosis codes specified in paragraph (5) of this subsection are exempt from the stop-loss methodology and the entire admission shall be reimbursed at a fair and reasonable rate." As stated above, the Division has found that the primary diagnosis is a code specified in Division rule at 28 TAC §134.401(c)(5); therefore, the disputed services are exempt from the stop-loss methodology and the entire admission shall be reimbursed at a fair and reasonable rate pursuant to Division rule at 28 TAC §134.1
3. This dispute also relates to air ambulance services that shall be reimbursed at a fair and reasonable rate pursuant to Division rule at 28 Texas Administrative Code §134.1 and Texas Labor Code §413.011(d).
4. On January 19, 2012, the division requested a detailed description of the air ambulance services. The requestor responded by stating that "Life Flight air ambulance is wholly owned by Memorial Hermann Hospital System. Back at this time, the hospital was still doing its own billing as you can see from the attached bill. …Life Flight only operates within a 150 mile radius of the Medical Center in Houston. So it does not transport patient from other states and operates solely in Texas."
5. 28 Texas Administrative Code §133.307(c)(2)(A), effective December 31, 2006, 31 *Texas Register* 10314, applicable to disputes filed on or after January 15, 2007, requires that the request shall include "a copy of all medical bill(s)… as originally submitted to the carrier and a copy of all medical bill(s) submitted to the carrier for reconsideration…". Review of the documentation submitted by the requestor finds that the requestor included copies of all the medical bills for the inpatient hospitalization, but did not include copies of any medical bills for the air ambulance services. The Division concludes that the requestor has not met the requirements of §133.307(c)(2)(A) for the air ambulance services.
6. 28 Texas Administrative Code §133.307(c)(2)(B), effective December 31, 2006, 31 *Texas Register* 10314, applicable to disputes filed on or after January 15, 2007, requires that the request shall include "a copy of each explanation of benefits (EOB)... relevant to the fee dispute or, if no EOB was received, convincing documentation providing evidence of carrier receipt of the request for an EOB." Review of the documentation submitted by the requestor finds that the request included copies of all EOBs for the inpatient hospitalization, but did not include any EOBs for the air ambulance service. Furthermore, the requestor did not provide convincing documentation to support that they requested an EOB from the carrier for the air ambulance services. The Division concludes that the requestor has not met the requirements of §133.307(c) (2)(B) for the air ambulance service.
7. 28 Texas Administrative Code §133.307(c)(2)(G), effective December 31, 2006, 31 *Texas Register* 10314, applicable to disputes filed on or after January 15, 2007, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) when the dispute involves health care for which the Division has not established a maximum allowable reimbursement (MAR), as applicable." Review of the submitted documentation finds that:
   - The requestor states in the position summary that "At the very least, the hospital should be reimbursed no less than 75% of its billed charges as clearly this case exceeded the stop loss threshold for total billed charges."
   - The requestor seeks reimbursement for this admission based upon the stop-loss reimbursement methodology which is not applicable per 28 Texas Administrative Code §134.401(c)(6).
   - The requestor did not submit documentation to support that the payment amount being sought is a fair and reasonable rate of reimbursement
   - The requestor also proposed an alternative reimbursement methodology in the position summary stating "The hospital billed its usual and customary charges in the total amount of $142,812.39 and $8,078.75, respectively…Requestor submits that a fair and reasonable rate for treatment of this injured employee is the usual and customary charges incurred since the carrier refused to conduct an audit to refute those charges. Requestor is owed an additional $114,064.02, plus interest."
   - The requestor did not provide documentation to demonstrate how it determined its usual and customary charges for the disputed services.
   - The requestor did not discuss or explain how it determined that reimbursement of the entire amount billed would yield a fair and reasonable reimbursement.

- The Division has previously found that “hospital charges are not a valid indicator of a hospital’s costs of providing services nor of what is being paid by other payors,” as stated in the adoption preamble to the Division’s former *Acute Care Inpatient Hospital Fee Guideline*, 22 *Texas Register* 6276. It further states that “Alternative methods of reimbursement were considered… and rejected because they use hospital charges as their basis and allow the hospitals to affect their reimbursement by inflating their charges…” 22 *Texas Register* 6268-6269. Therefore, the use of a hospital’s “usual and customary” charges cannot be favorably considered when no other data or documentation was submitted to support that the payment amount being sought is a fair and reasonable reimbursement for the services in dispute.
- The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
- The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307 for the air ambulance service. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

Authorized Signature

		1/31/2012
Signature	Medical Fee Dispute Resolution Officer	Date
		1/31/2012
Signature	Health Care Business Management Director	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.